STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505042	A. Building B. Wing	11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ballard Center	820 Northwest 95th Street Seattle, WA 98117

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide appropriate discharge instructions including a discharge summary or recapitulation of stay for 3 of 4 residents (Residents 2, 3 & 4), reviewed for discharge process. This failure placed the residents at risk for lack of knowledge regarding their medical status and medications at the time of discharge, a break in communication and continuity of care, unmet care needs and diminished quality of life. Findings included.Review of the facility's policy titled, Discharge Against Medical Advice [AMA], dated 03/22/2022, showed that AMA discharges will be processed in accordance with the resident's/representative's request to arrange for a safe appropriate discharge. Documentation will be completed as applicable.RESIDENT 2 Review of a face sheet showed Resident 2 admitted to the facility on [DATE] with diagnoses that included type II diabetes (a condition affecting a person's ability to produce a hormone to move sugar from food into the body's cells), protein-calorie malnutrition (lack of energy from food to meet the body's needs) and dysphagia (difficulty swallowing). Review of physician orders dated 09/16/2025, showed Resident 2 had an order for Nothing by Mouth, texture diet. It also showed an order dated 09/16/2025, for Glucerna (brand of liquid nutrition) that was administered through a gastrotomy tube (G-tube - a small tube placed directly into the stomach through the belly to help a person get food, liquids, or medicine when they cannot swallow normally) four times a day. It further showed that Resident 2 had an order dated 09/16/2025 for medication to treat type II diabetes and was administered once a day through their G-tube.Review of a discharge care plan printed on 10/30/2025, showed a focus of [Resident 2's] desire to discharge to the community, dated 09/23/2025. It showed a goal that [Resident 2] will have an ongoing discharge plan that provides for a safe and effective discharge. It further showed an intervention to Make referrals to community-based agencies, providers, and services communicating the residents' needs and barriers to care, dated 09/23/2025. Review of nursing progress notes dated 10/17/2025, showed Staff H, Social Services (SS), was informed by Resident 2 of their wish to leave the facility and return home, and that Resident 2 had left AMA on 10/17/2025. Further review of Resident 2's nursing progress notes did not show documentation of the facility's attempt(s) to provide Resident 2 with a discharge summary and/or discussion regarding reconciliation of medications prior to leaving the facility. Review of Resident 2's document titled Discharge Plan Documentation, dated 10/17/2025 showed incomplete sections for home/community status, doctors involved in care after discharge, follow-up tests/procedure already scheduled, skin condition, diet, current infections, assistance level with activities of daily living, therapy services, and summary of medication changes and/or discontinuations during stay.RESIDENT 3Review of a face sheet showed Resident 3 admitted to the facility on [DATE] with diagnoses that included type II diabetes and atrial fibrillation (a condition that causes irregular heartbeat). Review of physician orders dated 09/23/2025, showed Resident 3 had an order for medication used to prevent blood clots and was administered twice a day. It also showed an order for insulin (an injectable hormone to treat type II diabetes) that was administered before meals and at bedtime. Further review showed an order dated 10/10/2025, for Patient [Resident 3] may discharge with all current medications/treatment. Review of Resident 3's discharge care plan dated 10/10/2025, showed that [Resident 3] plans to go back to her apartment with a caregiver. It further showed a goal, dated 10/10/2025 that Resident will have an ongoing discharge plan that provides for a safe and effective discharge.Review of a nursing progress note dated 10/12/2025 at 12:36 PM, showed Resident 3 expressed to nursing staff their desire to go home on 10/12/2025 and that nursing informed Staff H. It showed that Staff H, mentioned [Resident 3's] discharge plan is ongoing and was to be finalized by Monday, 10/13/2025. It further showed that Staff H spoke to Resident 3 and that they agreed to wait until 10/13/2025 to be discharged from the facility. Review of a follow up nursing progress note dated 10/12/2025 at 2:00 PM, showed Resident left [the] facility against medical advice. Further review did not show documentation of the facility's attempts to provide Resident 3 with a discharge summary and/or discussion regarding reconciliation of medications prior to leaving the facility. Review of Resident 3's document titled Discharge Plan Documentation, dated 10/12/2025 showed incomplete sections for home/community status, doctors involved in care after discharge, follow-up tests/procedure already scheduled, skin condition, diet, current infections, assistance level with activities of daily living, therapy services, and summary of medication changes and/or discontinuations during stay. RESIDENT 4Review of a face sheet showed Resident 4 admitted to the facility on [DATE] with diagnosis that included history of falling and a healing left thigh fracture (broken bone). Review of Resident 4's discharge

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to verify and follow the code status (medical care elected by a person in the event their heart or breathing stops) for 1 of 3 residents (Resident 1), and failed to ensure licensed nursing staff had current cardiopulmonary resuscitation (CPR-an emergency procedure consisting of chest compressions combined with giving breaths of air) certification for 2 of 6 staff (Staff E & F), reviewed for CPR. The failure to follow advance directive (written document of a person's expressed emergency care) and timely CPR training for staff placed the residents at risk for unwanted CPR, avoidable trauma and negative health outcomes.Findings included.Review of the facility's undated policy titled, Advance Directive, showed that upon admission, staff will inform the resident of their right to execute an Advance Directive Form. It further showed that A copy of the Advance Directive is maintained as part of the resident's medical record.Review of the facility's undated policy titled, Emergency Procedure - Cardiopulmonary Resuscitation, showed It is the policy of this facility to adhere to residents' rights to formulate advance directives. In accordance with these rights, this facility will implement guidelines regarding CPR. Listed policy guidelines showed that if a resident experiences cardiac arrest, facility staff will provide medical care, In accordance with the resident's advance directives. It further showed CPR certified staff will be available at all times, and that Licensed nursing staff will maintain current CPR certification.RESIDENT 1Review of a face sheet showed Resident 1 admitted to the facility on [DATE].Review of a document titled Patient Transfer Form, dated [DATE] showed Resident 1 had diagnoses that included autoimmune hemolytic anemia (a condition where a person's immune system mistakenly attacks and destroys its own red blood cells, leaning to anemia [low red blood cell count]), End Stage Renal Disease (ESRD- means the kidneys have stopped working well enough to keep a person alive without special treatment) and dependence on dialysis (treatment for ESRD). Review of physician orders showed an order, dated [DATE], for DNR (do not resuscitate/perform CPR), and that a Physician Orders for Life Sustaining Orders (POLST-advance directive) was signed.Review of [DATE] Medication Administration Records (MAR) showed Resident 1's advance directive of DNR was transcribed on all MAR pages for staff reference. Review of a completed and signed POLST form, dated [DATE], showed Resident 1 elected Do Not Attempt Resuscitation (DNAR) and to Allow Natural Death, in the event Resident had no pulse and was not breathing. Review of a progress note dated [DATE] showed Resident 1 was found by Staff C, Registered Nurse (RN), unresponsive, no pulse, not breathing and unable to talk. It showed that Resident was immediately placed on the floor and CPR was administered. It also showed that paramedics arrived and took over performing CPR. It further showed that paramedics performed at least 11-12 rounds of CPR.In an interview on [DATE] at 4:09 PM, Staff B, Assistant Director of Nursing, stated that advance directives were discussed with residents upon admission and that staff were expected to follow elections made on the advance directives. In an interview on [DATE] at 5:40 PM, Staff C stated that they verified a resident's advance directive or code status by referencing the resident's completed POLST form which was kept in a binder at the nurses' station. Staff C stated that a resident's completed POLST forms was available in a resident's Electronic Health Record (EHR) under the Miscellaneous Tab. When asked how Resident 1's code status was verified on [DATE], Staff C stated that on [DATE], after finding Resident 1 unresponsive, Staff C verified with another nurse, Staff D, RN, by checking Resident 1's EHR for the POLST Form and in the binder. Staff C stated that a completed POLST form was not available for Resident 1 at the time and that they confirmed Resident 1's code status by referencing [the] discharge papers from where Resident 1 admitted from. Staff C further stated that verification of Resident 1's code status via physician orders was not performed and that No, we did not, went to the Miscellaneous Tab to check. When asked if physician orders in Resident 1's EHR were signed/approved orders by a provider, Staff C stated Yes, we didn't [did not] get a chance to see that. In a follow up interview and joint record review on [DATE] at 11:22 AM, Staff B, stated that staff verified a resident's code status during an emergency by referring to the master copy of the completed POLST that was kept in a binder at each nurses' station. Staff B stated that a resident's code status could be referenced in the resident's EHR via the resident profile and physician orders. A joint record review of Resident 1's completed POLST form showed DNAR was elected. Further joint record review of Resident 1's physician orders and [DATE] MAR showed an order dated [DATE] for DNR and that Resident 1's code status was transcribed on pages of their MAR. Staff C stated, Every page on the MAR has the advance directives, and that The expectation is to go by what the [physician] orders say